

PATIENT - RELATED VARIANCE REPORT

Operating Room/Quality Improvement Program

INCIDENT DATE	INCIDENT TIME	AM PM
INCIDENT LOCATION	<input type="checkbox"/> CR ROOM <input type="checkbox"/> CYSTO <input type="checkbox"/> HOLDING <input type="checkbox"/> CAST ROOM	
SURGEON	PROCEDURE	

Check type of incident and objectively describe it in the space below

<input type="checkbox"/> 1. Surgery Delay + 30 minutes <input type="checkbox"/> Anesthesia <input type="checkbox"/> Surgeon <input type="checkbox"/> Operating Room <input type="checkbox"/> Pre-Induction <input type="checkbox"/> Radiology <input type="checkbox"/> Patient Care Area <input type="checkbox"/> Laboratory <input type="checkbox"/> Other	<input type="checkbox"/> 6. Incomplete Patient ID <input type="checkbox"/> No ID Band on Patient <input type="checkbox"/> No Allergy Band on Patient <input type="checkbox"/> 7. Perioperative Injury to Patient <input type="checkbox"/> Breakdown in Skin Integrity <input type="checkbox"/> Burns <input type="checkbox"/> Sores <input type="checkbox"/> Falls <input type="checkbox"/> Transfer or Positioning Injury	<input type="checkbox"/> 12. Medication/IV Problems <input type="checkbox"/> 13. A. Blood Administration Problems <input type="checkbox"/> B. No Consent For Blood Administration <input type="checkbox"/> 14. Additional Procedure(s) Other Than Scheduled <input type="checkbox"/> 15 A. Return to OR Within 24 hrs for <input type="checkbox"/> Second Procedure <input type="checkbox"/> Control of Bleeding <input type="checkbox"/> 15 B. Return to OR greater than 24 hrs. <input type="checkbox"/> 16. Cardiac or Resp. Arrest <input type="checkbox"/> 17. Death <input type="checkbox"/> 18. Other (Specify and Describe Below)
<input type="checkbox"/> 2. Surgery Cancellation <input type="checkbox"/> After Admission to OR <input type="checkbox"/> After Induction	<input type="checkbox"/> 8. Major Break in Aseptic Technique <input type="checkbox"/> 9. Equipment or Instrumentation Problem Any Time During Surgery <input type="checkbox"/> Missing <input type="checkbox"/> Broken <input type="checkbox"/> Improperly Cleaned <input type="checkbox"/> Incorrect Set-Up	
<input type="checkbox"/> 3. Wrong Patient Brought to OR	<input type="checkbox"/> 10. Incorrect Count <input type="checkbox"/> Sponge <input type="checkbox"/> Sharps <input type="checkbox"/> Instrument	
<input type="checkbox"/> 4. Room Not Clean <input type="checkbox"/> Floors <input type="checkbox"/> Equipment <input type="checkbox"/> Furniture <input type="checkbox"/> Walls <input type="checkbox"/> Other	<input type="checkbox"/> 11. Specimens/Cultures <input type="checkbox"/> Lost <input type="checkbox"/> Mislabeled <input type="checkbox"/> Mishandled	
<input type="checkbox"/> 5. Incomplete or Incorrect Operative Consent		

Description of Incident:

Check here if continued on back ➡

Physician Notified?	NAME (print)	PHYSICIAN FINDINGS
<input type="checkbox"/> Yes <input type="checkbox"/> No	SIGNATURE	

Check here if continued on back ➡

SIGNATURE OF PERSON COMPLETING/TITLE	DATE
--------------------------------------	------

Reviewed By	<input type="checkbox"/> OR QA/ Chairperson <input type="checkbox"/> OR Director <input type="checkbox"/> Chief of Staff <input type="checkbox"/> Other	Referred To	<input type="checkbox"/> Quality Assurance/Improvement <input type="checkbox"/> Patient Relations <input type="checkbox"/> Other
-------------	--	-------------	--

Please forward to QA/ Chairperson as soon as possible.
The OR QA/ Chairperson will forward to appropriate department.